MARIN COUNTY
PHYSICIAN UNCOMPENSATED CARE RELIEF PAYMENT PROGRAM RULES
FOR EMERGENCY MEDICAL SERVICES
UNDER
SB 12/612 (MADDY) & AB 442 (EMSA)

OVERVIEW

The Marin County Department of Health and Human Services administers its Emergency Medical Services Fund pursuant to Chapter 1240, 1987 Statutes ("SB12-Maddy"), Health and Safety Code Part I, Division 2.5, Section 1797.98, and according to Chapter 1161, 2002 Statutes ("AB 442"), Health and Safety Code Section 101, and to Welfare and Institution Code Section 16952, in order to make relief payments for certain uncompensated emergency services. The Marin Emergency Services Fund is administered in three accounts; the Hospital Services Account; the Emergency Services/Trauma Account and the Physician Services Account. Up to 10% of the fund is set aside for administrative expenses. This document describes the policy and procedures applying to administration of the Physician Services Account.

WHO CAN SEEK REIMBURSEMENT FROM THE PHYSICIAN SERVICES ACCOUNT?

1. Physicians who have provided services as described in the "covered services" section of these rules.
2. Physicians who enroll in the program and agree to the Conditions of Participation in order to receive reimbursement. Each year, physicians shall submit an Affidavit of Certification for Claims Submission (Attachment A) with the first set of claims. The physician must also submit a completed W-9 form with their enrollment form.

COVERED SERVICEES

1. The services must not have been compensated to any extent through any other source of payment, including private insurance, Medi-Cal or MediCare, or patient payments. Payment must have been unsuccessfully sought at least twice and payment from the Fund cannot be sought until three months after the first attempt to bill the patient or responsible third party.
2. The services must be related to emergency medical conditions as defined in Health and Safety Code Section 1317.1 (see next section) and must be provided within 48 hours of the onset of care for the emergency incident.
3. Once the patient is stabilized, even if it is within the initial 48-hour period, no services will be covered.
4. Services provided by physicians employed by a county hospital or by physicians working in a primary care clinic that receives Tobacco Tax funds cannot be reimbursed from the fund.

Claims can only be paid up to the statutory maximum of fifty (50) percent of the County's established rate schedule. In Marin County, claims will be paid up to fifty (50) percent of 250% of the Medicare RBRVS rate for that service*. If the amount of the approved claims in any given period exceeds the available funds, then the available funds will be prorated equitably among all

* The 2003 Medicare rate schedule will apply to claims submitted for dates of services through December 31, 2004. To the extent that the rate schedules are available, the applicable rate schedule will be updated each year after that (the 2004 rate schedule will be used during 2005, the 2005 schedule during 2006 and so on.)

claimants with approved claims based on the proportion of their approved claims to all approved claims for that service period.

RELIEF PAYMENT CLAIM PROCESS

1. ***Enrollment***
   Providers enroll in the program through the submission of the first set of claims. Accompanying the first claim submission should be a signed Affidavit of Certification for Claims Submissions (Attachment A) and a completed W-9. Prior to the distribution by the County of any remaining funds to reimburse up to an additional 50% of claim amounts, a second Certification will need to be submitted.

   Physicians working for county hospitals or in a clinic that receives Proposition 99 (Tobacco Tax) funds are not eligible for the program.

2. ***Services that can be Claimed:***
   The Services provided must be emergency services, provided in a hospital before the patient is stabilized, and within 48 hours of the initial emergency visit.
   a. Emergency services that are covered: The services must be:
      i. Related to emergency medical conditions as defined in Health and Safety Code Sections 1297.98a-g, and 1317.1*;

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* 1317.1. Unless the context otherwise requires, the following definitions shall control …:
(a) (1) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.
(2) (A) "Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.
…
(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
(1) Placing the patient's health in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.
(c) "Active labor" means a labor at a time at which either of the following would occur:
(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.
(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.
…
(j) A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no

ii. Must be provided within 48 hours of the onset of emergency care services.
iii. Once the patient is stabilized, even if it is within the initial 48-hour period, no services will be covered.

3. ***There must be no other payment for the claim:***.
The physician must be able to verify that:
   a. No payment has been received after at least two billing attempts: The patient or responsible third party must have been billed at least twice, with no payment received or with a formal notification that no payment is forthcoming.
   b. At least three months have elapsed since the first billing attempt.
   c. For the fiscal year 2003-2004, service date must be no more than two years prior to the submission of the claim. For services delivered after July 1, 2004, claims must be submitted no later than nine months from the date of service.
   d. The patient has been provided with the California DHS EMSA Contract Back Program Notice of Privacy Practices addressing the use of information collected as a result of the services provided.

4. ***Amount the can be claimed:***
Payments will be based upon the lesser of charges presented or 250% of the Medicare RBRVS fee for the procedure. Note that reimbursement is limited to 50% of this rate schedule.

4. ***How to Submit a Claim:***
   a. Claims should be submitted on a CMS (HCFA) 1500 Claim Form. Claims may be either typed or hand-written.
   b. Electronic submission of claims will be accommodated after exchange of necessary test information to ensure that the electronic transmission works.
   c. Claims should be accompanied by the Claim Verification Form (Attachment B).
   d. Claims should be submitted to.
   Marin County Department of Health and Human Services
   Office of Finance – Physician's Services Accounts
   Attention: EMS Fund Accounting
   20 North San Pedro Road, Suite 2028
   San Rafael, CA 94903

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material deterioration of the patient's condition is likely to result from, or occur during, a transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.

COUNTY PAYMENT PROCESS

1. Availability of Monies
   There is a set amount of money for paying physician claims. Payment of physician claims is contingent upon the County receiving monies, and sufficient money remaining in the account to pay claims. Eligible claims submitted in a timely manner will be paid by the County at the maximum allowable rate of 50% of the County rate schedule (i.e., 50% of 250% of Medicare RBRVS) until the funds in these Physician Services Accounts are exhausted or on a prorated basis if total claims exceed available funds.

2. Distribution of Surplus Remaining at the end of Fiscal Year.
   a) Throughout the fiscal year, funds will be distributed based on claims submitted, with payments equal to 50% of the submitted claim (based upon 250% of the Medicare rate).
   b) Prior to the submission of the required annual report of the fund to the legislature (April 15th), the funds remaining in the account will be distributed as follows:
      i. 15% of the fund balance will be put into reserve.
      ii. Remaining funds at June 30, 2004 will be distributed based upon the proportionate aggregate dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during fiscal years 2001-2002, 2002-2003 and 2003-2004. The final date to submit claims for the services delivered prior to the end of the 2003-2004 fiscal year for inclusion in the calculation of the surplus distribution is December 31, 2004. Subsequent fiscal year surpluses will be distributed proportionately based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims for services delivered during each fiscal year, and submitted within the six months of the end of the fiscal year.

3. No Other Reimbursement for Indigent Care
   The County is not obligated to make payments to physicians for uncompensated patient care services except as expressly provided for in these program rules and claim procedure.

4. Patient Confidentiality
   The County shall protect the confidentiality of the patient information submitted and comply with all applicable federal, state, and local statutes and regulations governing the protection of patient medical information.

5. County Rate Schedule
   The County's rate schedule is based upon the lesser of charges presented or 250% of the Medicare RBRVS rate for the procedure. For dates of service up to December 31, 2004, the 2003 Medicare rate schedule shall apply. To the extent that the schedule is available, the 2004 Medicare rate schedule will apply for claims for services provided in 2005; the 2005 schedule for services provided in 2006, and so on.

PHYSICIAN REFUNDS TO COUNTY

If, after receiving payment from County under this Uncompensated Care Relief Payment Program for uncompensated patient care services, the physician receives any payment from the patient or responsible party for the same services, the physician shall notify the Marin County Department of Health and Human Services Office of Finance, and County's payment on any subsequent claim submitted by the physician shall be reduced accordingly by the amount of the payment received from the patient or responsible party, but not to exceed the amount paid by the County for this same service. In the event that there is no subsequent submission by the physician of a claim to the County for uncompensated services within one year of such notice, the physician shall refund to the County an amount equal to the amount collected from the patient or responsible party, but not to exceed the amount of County's payment for the same patient care services.

PHYSICIAN RECORDS, AUDIT, AND PAYMENT ADJUSTMENT OBLIGATIONS

1. The physician shall maintain complete and accurate records sufficient to fully and accurately reflect the services and costs for which a claim has been made. Such records shall include, but are not limited to, patient name and identifying information, services provided, dates of service, charges, and payments received. Additionally, such records shall include proof of all billing efforts made and required by these rules.
2. All such records shall be retained by the physician for a minimum of three years following the date of service.
3. Such records shall be made available to representatives of County's Auditor-Controller and/or to representatives of the Health and Human Services Department, and to representatives of the State, upon request, at all reasonable times during such three-year period for the purpose of inspection, audit, and copying.
4. If an audit, conducted by County or State representatives, of physician or hospital records, or both, relating to the services for which a claim was made and paid hereunder, finds that (1) the records do not support the emergency medical nature of all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the services, or (3) the physician failed either to report or refund payments from other sources as required herein, or (4) the records do not substantiate the required billing and collection efforts, the physician shall, upon receipt of County billing therefore, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

APPEAL PROCEDURES

Disputes regarding rejection of claims, amount of payment, or any other issue related to this claim procedure must be filed with the County Health and Human Services Department's Chief Fiscal Officer within 30 days of payment or denial of the claim. The County is not responsible for damages or costs which result from either the disputed action or the filing of an appeal. Settlement in favor of the physician cannot exceed 50% of the applicable Medicare rate schedule.

Mail appeals to:
Frima Stewart, Director, Public Health Services Division
Health and Human Services Department
20 North San Pedro Road, Suite 2028

San Rafael, CA 94903

Appeals that cannot be resolved at this level shall be submitted to an arbitrator, pursuant to the California Code of Civil Procedures, Title 9, Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285).

EFFECTIVE DATE

This procedure is effective June 15, 2004. Claims received after that date will only be processed if consistent with this procedure.

Attachments

A: Affidavit of Certification for Claims Submission

ATTACHMENT A – Affidavit of Certification for Claim Submissions

I certify that all claims for reimbursement I submit for uncompensated costs will meet the following conditions:

1. The services will be provided as part of the treatment needed to stabilize the patient from an emergency condition.
2. That all reasonable attempts will be made to ascertain whether the client is eligible for any kind of insurance, including Medi-Cal, including as appropriate soliciting identification information such as social security numbers.
3. The patient or responsible party will have been billed at least twice, no payment will have been received for these services, and it will have been at least 90 (ninety) days since the first billing attempt.
4. The patient has been provided with the California DHS EMSA Contract Back Program Notice of Privacy Practices addressing the use of information collected as a result of the services provided.
5. That all claims will be submitted in accordance with existing programs rules.

By: _____ Dated: _____
(Signature of Physician)

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(Typed or Printed Name of Physician)